THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
800-414-0168
617-973-0800
www.mass.gov/dph/boards

INSTRUCTIONS FOR LICENSE APPLICATION

General Information: Applicants for Nursing Home Administrator licensure MUST have completed a Board approved Administrator in Training internship to be eligible to submit a licensure application and take the national examination.

1. All application materials, including forms that are filled out by other individuals, must be submitted at the same time in a large envelope.

2. Provide a self-addressed envelope to your endorsers with your Reference Forms, Physician Form, and Administrator Certificate of Internship Training. After the individual has completed the form, he/she must seal it in the return envelope you provide, sign his/her name across the envelope seal, and return it to you.

3. Once the application packet is submitted, the Board will provide you with information regarding contacting Professional Examination Services to schedule a test date. For more information, please go to the National Association of Boards of Examination of Long Term Care Administrators' [NAB] *Information for Candidates, Nursing Home Administrators* handbook available at www.nabweb.org.

4. Retain a copy of the complete application package for your records.

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LICENSE APPLICATION PACKET CHECKLIST

The following must be included for a complete application. Please complete and enclose this checklist with your application. Incomplete applications will be RETURNED to you.

_____Application Form
- _____ Reference List
- _____ Photograph [2"x2", passport style]
- _____ Affidavit signed and notarized

_____ Fee: $51.00, payable by check or money order to the Commonwealth of Massachusetts NHA

_____ Four Reference Completed Reference Forms in signed, sealed envelopes:
- ____ 3 professional
- ____ 1 personal

_____ Physician Form

_____ Administrator Affidavit Certificate of Internship Training [in a signed, sealed envelope]

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All Questions Must Be Completed

LICENSE APPLICATION
FEE: $51. 00 CHECK OR MONEY ORDER
APPLICATION

1. Applicant Name:_____
   (Last) (First) (Middle)

   Maiden Name/Other Name (if applicable):

   _____
   (Last) (First) (Middle)

2. Address:

   _____ _____
   (No.) (Street) (Apt. #)

   _____
   (City/Town) (State) (Zip Code)

3. Most Recent Previous Address:

   _____
   (No.) (Street) (Apt. #)

   _____
   (City/Town) (State) (Zip Code)

4. Business Address (If Applicable):_____ _____
   (No.) (Street) (Apt. #)

   _____
   (City/Town) (State) (Zip Code)

5. Telephone Number(s) Day:_____ Evening:_____

6. Date of Birth: ____/____/____ (mm/dd/yyyy) 7. Place of Birth: _____

8. Sex: M F (Circle One) 9.Height: _____ 10.Weight: _____ 11. Eye Color:_____

12. Mother's Maiden Name:

_____

13. Social Security Number **(Mandatory)**:_____
Pursuant to MG.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax and child support laws of the Commonwealth.

ALL QUESTIONS MUST BE ANSWERED

1. List any licenses/certifications you hold in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/certification was originally issued.
Submit a certificate of standing from each state or jurisdiction in a signed sealed envelope. Certifications may be mailed directly to the Board.

Lic. No.	Profession	Issuing Jurisdiction
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):
_____
_____

3. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):
_____
_____

4. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction?
Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary)
_____
_____

5. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):
_____
_____

6. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of $100 or less was imposed. Yes: ☐ No: ☐
_____
_____
_____

REFERENCES

List the names of the three professional people whom you have asked to file a reference form with this application. **(NOT RELATIVES OR SUBORDINATES)**

1. Name _____

   Title or position _____

2. Name _____

   Title or position _____

3. Name _____

   Title or position _____

Personal Character Reference: Provide the name of a personal reference who will complete a reference form to be submitted with this application.

4. Name _____

   Years Known _____

AFFIDAVIT

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Nursing Home Administrators any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Nursing Home Administrators to release information contained in this application in association with its processing.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data. As an applicant for authorization to practice as a Nursing Home Administrator, I understand that a criminal record check may be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided in this application pursuant to G.L. c. 112, ss. 23R through 23BB is correct to the best of my knowledge.

I agree to abide by the rules and regulations for licensing in Nursing Home Administration as defined in and promulgated pursuant to M.G.L. c. 112, ss. 108-117. I attest that the statements made herein are truthful and are made under the pains and penalties of perjury.

I further attest that, pursuant to MG.L. c. 62C, s. 49A, to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

Please attach recent 2"x 2" Photograph here

_____ _____

Signature of applicant Date

Notary Name (print) _____

Notary Signature _____

My commission expires: _____

[Seal]

Attach a non-refundable fee of $51.00 (check or Money Order) payable to the Commonwealth of Massachusetts.

ATTENTION:

MAKE 4 COPIES OF THE FOLLOWING 2 PAGES

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REFERENCE FORM

You have been requested to provide reference information for _____, an applicant for registration as a Nursing Home Administrator in Massachusetts under the provisions of Section 74, Chapter 13 of the General Laws of this Commonwealth. Pertinent information concerning the applicant will be helpful to the Massachusetts Board of Registration of Nursing Home Administrators.

In order that the provisions of the licensing law may be effective in safeguarding public health, safety and welfare, the Board of Registration of Nursing Home Administrators has been charged with the responsibility of limiting the use of the title "Nursing Home Administrator" only to those who are found qualified and suitable for that profession. As one of the applicant's references, you are familiar with his/her professional work or have knowledge of his/her ability, character and reputation. The Board would appreciate information that bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence and character.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.

MASSACHUSETTS BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS

REFERENCE FORM

Please type or print clearly:

1. NAME OF APPLICANT_____
2. PROFESSIONAL, OR OTHER RELATIONSHIP TO APPLICANT

_____
_____
_____
_____

3. NUMBER OF YEARS YOU HAVE KNOWN APPLICANT _____
4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE PERSONAL KNOWLEDGE:
   a. Professional knowledge and experience:

_____
_____
_____

   b. Character with respect to honesty, integrity, and general conduct:

_____
_____
_____

5. DO YOU RECOMMEND THE APPLICANT FOR LICENSURE AS A NURSING HOME ADMINISTRATOR? YES _____ NO _____ If NO, please attach a detailed written explanation of your reasons for not recommending this applicant.
6. OTHER COMMENTS:

_____
_____
_____
_____
_____

(Attach an additional sheet of paper, if you wish to make additional comments)

I hereby certify that the information given above is correct to the best of my knowledge and belief, and opinions expressed above represent my best judgment. I hereby agree to provide further information to the Board if requested to do so.

_____
Name (type or print clearly) Signature

_____
Business Address Date

_____
City/State Zip Code Occupation

_____
Home Address City/State Zip Code

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PHYSICIAN FORM

1. NAME OF APPLICANT: _____

2. NAME OF LICENSED PHYSICIAN: _____

3. ADDRESS OF PHYSICIAN: _____
   No. Street Apt. #
   _____
   City/Town State Zip Code

4. PHYSICIAN STATE LICENSE NUMBER: _____
   # Expiration Date

I hereby certify that the above named applicant is in good health and has no mental or physical impairment that would prevent him or her from discharging the responsibilities of a Nursing Home Administrator.

_____ _____
Physician Signature Date

Once you have completed this form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.

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ADMINISTRATOR AFFIDAVIT
CERTIFICATE OF INTERNSHIP TRAINING

_____ _____
(Trainee Name) (Degree Level)

I, _____, _____, hereby certify that
(Administrator) (License number)
the trainee named above has trained in the _____
(Name of Nursing Home)
_____, from _____ to _____, working
(mm/dd/yyyy) (mm/dd/yyyy)
_____hours per week, for a total of _____ hours.

During this training period, the trainee named above, has worked exclusively as an Administrator In Training and has not simultaneously held any other position in this facility. During the course of this training, the trainee was exposed to all aspects of nursing home management and the operation of the named facility, including the following: admittance procedures, patient care policies, utilization review processes, in-service training procedures, social services, medical records, housekeeping and sanitation, dietary and kitchen operations, medical department and applicable rehabilitation procedures, laundry services, purchasing procedures, personnel department procedures and policies, management functions including budgeting, billing, accounts receivable and payable, and departmental scheduling, etc.

I have been licensed in good standing for a least five years.

Under the penalty of perjury, this affidavit has been signed AFTER the completion date of the AIT.

_____ _____
Signature of Administrator Date

_____ _____
Notary Public Notary Expiration Date

_____
Effective Date of This Document Seal